S. 1171, a bill to amend title XVIII of the Social Security Act to restore State authority to waive the 35-mile rule for designating critical access hospitals under the Medicare Program.

S. 1177

At the request of Mr. KOHL, the name of the Senator from Maine (Ms. COLLINS) was added as a cosponsor of S. 1177, a bill to improve consumer protections for purchasers of long-term care insurance, and for other purposes.

S. 1304

At the request of Mr. GRASSLEY, the name of the Senator from Massachusetts (Mr. KIRK) was added as a cosponsor of S. 1304, a bill to restore the economic rights of automobile dealers, and for other purposes.

S. 1340

At the request of Mr. LEAHY, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 1340, a bill to establish a minimum funding level for programs under the Victims of Crime Act of 1984 for fiscal years 2010 to 2014 that ensures a reasonable growth in victim programs without jeopardizing the long-term sustainability of the Crime Victims Fund.

S. 1360

At the request of Mr. BINGAMAN, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 1360, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income amounts received on account of claims based on certain unlawful discrimination and to allow income averaging for backpay and frontpay awards received on account of such claims, and for other purposes.

S. 1421

At the request of Mr. LEVIN, the name of the Senator from Pennsylvania (Mr. CASEY) was added as a cosponsor of S. 1421, a bill to amend section 42 of title 18, United States Code, to prohibit the importation and shipment of certain species of carp.

S. 1584

At the request of Mr. MERKLEY, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 1584, a bill to prohibit employment discrimination on the basis of sexual orientation or gender identity.

S. 1608

At the request of Ms. STABENOW, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 1608, a bill to prepare young people in disadvantaged situations for a competitive future.

S. 1685

At the request of Mr. SANDERS, the names of the Senator from Maryland (Ms. MIKULSKI) and the Senator from New Mexico (Mr. UDALL) were added as cosponsors of S. 1685, a bill to provide an emergency benefit of $250 to seniors, veterans, and persons with disabilities in 2010 to compensate for the lack of a cost-of-living adjustment for such year, and for other purposes.

S. 1700

At the request of Mr. LUGAR, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 1700, a bill to require certain issuers to disclose payments to foreign governments for the commercial development of oil, natural gas, and minerals, to express the sense of Congress that the President should disclose any payment relating to the commercial development of oil, natural gas, and minerals on Federal land, and for other purposes.

S. 1723

At the request of Mr. CORKER, the name of the Senator from Utah (Mr. BENNETT) was added as a cosponsor of S. 1723, a bill to authorize the Secretary of the Treasury to delegate management authority over troubled assets purchased under the Troubled Asset Relief Program, to require the establishment of a trust to manage assets of certain designated TARP recipients, and for other purposes.

S. 1776

At the request of Ms. STABENOW, the names of the Senator from New Mexico (Mr. UDALL), the Senator from Pennsylvania (Mr. CASEY), the Senator from Alaska (Mr. BEGICH), and the Senator from Vermont (Mr. LEAHY) were added as cosponsors of S. 1776, a bill to amend title XVIII of the Social Security Act to provide for the update under the Medicare physician fee schedule for years beginning with 2010 and to sunset the application of the sustainable growth rate formula, and for other purposes.

S. 1783

At the request of Mr. FRANKEN, the name of the Senator from Minnesota (Ms. KLOBUCHAR) was added as a cosponsor of S. 1783, a bill to amend the Agricultural Marketing Act of 1946 to provide for country of origin labeling for dairy products.

S. RES. 307

At the request of Mr. BUNNING, the name of the Senator from Georgia (Mr. ISAKSON) was added as a cosponsor of S. Res. 307, a resolution to require that all legislative matters be available and fully scored by CBO 72 hours before consideration by any subcommittee or committee of the Senate or on the floor of the Senate.

S. RES. 312

At the request of Mr. DURBIN, the name of the Senator from New Jersey (Mr. MENENDEZ) was added as a cosponsor of S. Res. 312, a resolution expressing the sense of the Senate on empowering and strengthening the United States Agency for International Development (USAID).

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. FRANKEN:

S. 1788. A bill to direct the Secretary of Labor to issue an occupational safety and health standard to reduce injuries to patients, direct-care registered nurses, and all other health care workers by establishing a safe patient handling and injury prevention standard, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Mr. FRANKEN. Mr. President, today I am introducing a bill to help keep our country's invaluable nurses and health care workers safe from debilitating injuries suffered on the job. This legislation will require workplace standards that eliminate the manual lifting of patients—the primary cause of musculoskeletal disorders in the health care profession. And I want to first thank my colleague in the House, Representative CONYERS of Michigan's 14th District, for his leadership on this issue and for the impressive work he put into crafting this bill.

When we think of dangerous working conditions, mines or construction sites might come to mind. But in fact, work performed in hospitals and nursing homes contributes to thousands of cases of musculoskeletal disorders in nurses and health care workers each year. These injuries require time away from work, and unfortunately, many workers suffering from chronic back injury are forced to leave the profession permanently. Nurses and health care workers deserve better—they shouldn't have to sacrifice their safety and their livelihood to help others, especially when many of these injuries could be prevented.

The manual lifting of patients is the primary cause of musculoskeletal injuries, and can be eliminated with the use of lifting equipment. Many health care facilities already have this equipment available, and studies have shown that it reduces injuries to workers, increases safety for patients, and is a cost-effective investment over several years.

This legislation would require the Department of Labor to propose standards for safe patient handling to prevent musculoskeletal disorders for health care workers, and eliminate manual lifting of patients through the use of lift equipment. It would also require health care facilities to develop safe patient handling plans and provide training on safe patient handling techniques.

Under the bill, health care workers would have the right to refuse assignments that are not in compliance with safe patient handling standards and be protected from employer retaliation against workers who refuse these assignments or report violations.

To help health care facilities to make this transition, the bill creates a new grant program for needy health care facilities that require financial assistance to purchase safe patient handling equipment.

I urge my colleagues to support the Nurse and Health Care Worker Protection Act. All of us benefit from the services these professionals provide, and by passing this legislation, we can help ensure they are able to safely continue in their important careers.

Mr. President, I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1788

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; FINDINGS; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Nurse and Health Care Worker Protection Act of 2009''.

(b) FINDINGS.—Congress finds the following:

(1) In 2007, direct-care registered nurses ranked seventh among all occupations for the number of cases of musculoskeletal disorders resulting in days away from work—8,580 total cases. Nursing aides, orderlies, and attendants sustained 24,340 musculoskeletal disorders in 2007, the second highest of any occupation. The leading cause of these injuries in health care are the result of patient lifting, transferring, and repositioning injuries.

(2) The physical demands of the nursing profession lead many nurses to leave the profession. Fifty-two percent of nurses complain of chronic back pain and 38 percent suffer from pain severe enough to require leave from work. Many nurses and other health care workers suffering back injury do not return to work.

(3) Patients are not at optimum levels of safety while being lifted, transferred, or repositioned manually. Mechanical lift programs can substantially reduce skin tears suffered by patients and the frequency of patients being dropped, thus allowing patients a safer means to progress through their care.

(4) The development of assistive patient handling equipment and devices has essentially rendered the act of strict manual patient handling unnecessary as a function of nursing care.

(5) A growing number of health care facilities have incorporated patient handling technology and have reported positive results. Injuries among nursing staff have dramatically declined since implementing patient handling equipment and devices. As a result, the number of lost work days due to injury and staff turnover has declined. Studies have also shown that assistive patient handling technology successfully reduces workers' compensation costs for musculoskeletal disorders.

(6) Establishing a safe patient handling and injury prevention standard for direct-care registered nurses and other health care workers is a critical component in protecting nurses and other health care workers, addressing the nursing shortage, and increasing patient safety.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. SAFE PATIENT HANDLING AND INJURY PREVENTION STANDARD.

(a) RULEMAKING.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Labor, shall, pursuant to section 6 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 655), propose a standard on safe patient handling and injury prevention (in this section such standard referred to as the ''safe patient handling and injury prevention standard'') under such section to prevent musculoskeletal disorders for direct-care registered nurses and all other health care workers handling patients in health care facilities. A final safe patient handling and injury prevention standard shall be promulgated not later than 2 years after the date of the enactment of this Act.

(b) REQUIREMENTS.—The safe patient handling and injury prevention standard shall require the use of engineering controls to perform lifting, transferring, and repositioning of patients and the elimination of manual lifting of patients by direct-care registered nurses and all other health care workers, through the use of mechanical devices to the greatest degree feasible except where the use of safe patient handling practices can be demonstrated to compromise patient care. The standard shall apply to all health care employers and shall require at least the following:

(1) Each health care employer to develop and implement a safe patient handling and injury prevention plan within 6 months of the date of promulgation of the final standard, which plan shall include hazard identification, risk assessments, and control measures in relation to patient care duties and patient handling.

(2) Each health care employer to purchase, use, maintain, and have accessible an adequate number of safe lift mechanical devices not later than 2 years after the date of issuance of a final regulation establishing such standard.

(3) Each health care employer to obtain input from direct-care registered nurses, health care workers, and employee representatives of direct-care registered nurses and health care workers in developing and implementing the safe patient handling and injury prevention plan, including the purchase of equipment.

(4) Each health care employer to establish and maintain a data system that tracks and analyzes trends in injuries relating to the application of the safe patient handling and injury prevention standard and to make such data and analyses available to employees and employee representatives.

(5) Each health care employer to establish a system to document in each instance when safe patient handling equipment was not utilized due to legitimate concerns about patient care and to generate a written report in each such instance. The report shall list the following:

(A) The work task being performed.

(B) The reason why safe patient handling equipment was not used.

(C) The nature of the risk posed to the worker from manual lifting.

(D) The steps taken by management to reduce the likelihood of manual lifting and transferring when performing similar work tasks in the future.

Such reports shall be made available to OSHA compliance officers, workers, and their representatives upon request within one business day.

(6) Each health care employer to train nurses and other health care workers on safe patient handling and injury prevention policies, equipment, and devices at least on an annual basis. Such training shall include providing information on hazard identification, assessment, and control of musculoskeletal hazards in patient care areas and shall be conducted by an individual with knowledge in the subject matter, and delivered, at least in part, in an interactive classroom-based and hands-on format.

(7) Each health care employer to post a uniform notice in a form specified by the Secretary that—

(A) explains the safe patient handling and injury prevention standard;

(B) includes information regarding safe patient handling and injury prevention policies and training; and

(C) explains procedures to report patient handling-related injuries.

(8) Each health care employer to conduct an annual written evaluation of the implementation of the safe patient handling and injury prevention plan, including handling procedures, selection of equipment and engineering controls, assessment of injuries, and new safe patient handling and injury prevention technology and devices that have been developed. The evaluation shall be conducted with the involvement of nurses, other health care workers, and their representatives and shall be documented in writing. Health care employers shall take corrective action as recommended in the written evaluation.

(c) INSPECTIONS.—The Secretary of Labor shall conduct unscheduled inspections under section 8 of the Occupational Safety and Health Act of 1970 (29 U.S.C. 657) to ensure implementation of and compliance with the safe patient handling and injury prevention standard.

SEC. 3. PROTECTION OF DIRECT-CARE REGISTERED NURSES AND HEALTH CARE WORKERS.

(a) REFUSAL OF ASSIGNMENT.—The Secretary shall ensure that a direct-care registered nurse or other health care worker may refuse to accept an assignment from a health care employer if—

(1) the assignment would subject the worker to conditions that would violate the safe patient handling and injury prevention standard; or

(2) the nurse or worker has not received training described in section 2(a)(5) that meets such standard.

(b) RETALIATION FOR REFUSAL OF LIFTING ASSIGNMENT BARRED.—

(1) NO DISCHARGE, DISCRIMINATION, OR RETALIATION.—No health care employer shall discharge, discriminate, or retaliate in any manner with respect to any aspect of employment, including discharge, promotion, compensation, or terms, conditions, or privileges of employment, against a direct-care registered nurse or other health care worker based on the nurse's or worker's refusal of a lifting assignment under subsection (a).

(2) NO FILING OF COMPLAINT.—No health care employer shall file a complaint or a report against a direct-care registered nurse or other health care worker with the appropriate State professional disciplinary agency because of the nurse's or worker's refusal of a lifting assignment under subsection (a).

(c) WHISTLEBLOWER PROTECTION.—

(1) RETALIATION BARRED.—A health care employer shall not discriminate or retaliate in any manner with respect to any aspect of employment, including hiring, discharge, promotion, compensation, or terms, conditions, or privileges of employment against any nurse or health care worker who in good faith, individually or in conjunction with another person or persons—

(A) reports a violation or a suspected violation of this Act or the safe patient handling and injury prevention standard to the Secretary of Labor, a public regulatory agency, a private accreditation body, or the management personnel of the health care employer;

(B) initiates, cooperates, or otherwise participates in an investigation or proceeding

brought by the Secretary, a public regulatory agency, or a private accreditation body concerning matters covered by this Act; or

(C) informs or discusses with other individuals or with representatives of health care employees a violation or suspected violation of this Act.

(2) GOOD FAITH DEFINED.—For purposes of this subsection, an individual shall be deemed to be acting in good faith if the individual reasonably believes—

(A) the information reported or disclosed is true; and

(B) a violation of this Act or the safe patient handling and injury prevention standard has occurred or may occur.

(d) COMPLAINT TO SECRETARY.—

(1) FILING.—A direct-care registered nurse, health care worker, or other individual may file a complaint with the Secretary of Labor against a health care employer that violates this section within 180 days of the date of the violation.

(2) RESPONSE TO COMPLAINT.—For any complaint so filed, the Secretary shall—

(A) receive and investigate the complaint;

(B) determine whether a violation of this Act as alleged in the complaint has occurred; and

(C) if such a violation has occurred, issue an order that sets forth the violation and the required remedy or remedies.

(3) REMEDIES.—The Secretary shall have the authority to order all appropriate remedies for such violations.

(e) CAUSE OF ACTION.—Any direct-care registered nurse or other health care worker who has been discharged, discriminated, or retaliated against in violation of this section may bring a cause of action in a United States district court. A direct-care registered nurse or other health care worker who prevails on the cause of action shall be entitled to the following:

(1) Reinstatement, reimbursement of lost wages, compensation, and benefits.

(2) Attorneys' fees.

(3) Court costs.

(4) Other damages.

(f) NOTICE.—A health care employer shall include in the notice required under section 2(b)(7) an explanation of the rights of direct-care registered nurses and health care workers under this section and a statement that a direct-care registered nurse or health care worker may file a complaint with the Secretary against a health care employer that violates the safe patient handling and injury prevention standard, including instructions for how to file such a complaint.

(g) ADDITION TO CURRENT PROTECTIONS.—The worker protections provided for under this section are in addition to protections provided in section 11(c) of the Occupational Safety and Health Act of 1970 (29 U.S.C. 660(c)).

SEC. 4. APPLICATION OF SAFE PATIENT HANDLING AND INJURY PREVENTION STANDARD TO HEALTH CARE FACILITIES NOT COVERED BY OSHA.

(a) IN GENERAL.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)(V), by inserting ''and safe patient handling and injury prevention standard (as initially promulgated under section 2 of the Nurse and Health Care Worker Protection Act of 2009)'' before the period at the end; and

(2) in subsection (b)(4)—

(A) in subparagraph (A), inserting ''and the safe patient handling and injury prevention standard'' after ''Bloodborne Pathogens standard''; and

(B) in subparagraph (B), inserting ''or the safe patient handling and injury prevention standard'' after ''Bloodborne Pathogens standard''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to health care facilities 1 year after date of issuance of the final safe patient handling and injury prevention standard required under section 2.

SEC. 5. FINANCIAL ASSISTANCE TO NEEDY HEALTH CARE FACILITIES IN THE PURCHASE OF SAFE PATIENT HANDLING AND INJURY PREVENTION EQUIPMENT.

(a) IN GENERAL.—The Secretary of Health and Human Services shall establish a grant program that provides financial assistance to cover some or all of the costs of purchasing safe patient handling and injury prevention equipment for health care facilities, such as hospitals, nursing facilities, home health care, and outpatient facilities, that—

(1) require the use of such equipment in order to comply with the safe patient handling and injury prevention standard; but

(2) demonstrate the financial need for assistance for purchasing the equipment required under such standard.

(b) APPLICATION.—No financial assistance shall be provided under this section except pursuant to an application made to the Secretary of Health and Human Services in such form and manner as the Secretary shall specify.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for financial assistance under this section $200,000,000, of which $50,000,000 will be available specifically for home health agencies or entities. Funds appropriated under this subsection shall remain available until expended.

SEC. 6. DEFINITIONS.

For purposes of this Act:

(1) DIRECT-CARE REGISTERED NURSE.—The term ''direct-care registered nurse'' means an individual who has been granted a license by at least one State to practice as a registered nurse and who provides bedside care or outpatient services for one or more patients or residents.

(2) HEALTH CARE WORKER.—The term ''health care worker'' means an individual who has been assigned to lift, reposition, or move patients or residents in a health care facility.

(3) EMPLOYMENT.—The term ''employment'' includes the provision of services under a contract or other arrangement.

(4) HEALTH CARE EMPLOYER.—The term ''health care employer'' means an outpatient health care facility, hospital, nursing home, home health care agency, hospice, federally qualified health center, nurse managed health center, rural health clinic, or any similar health care facility that employs direct-care registered nurses or other health care workers.

By Mr. DURBIN (for himself, Mr. LEAHY, Mr. SPECTER, Mr. FEINGOLD, Mr. CARDIN, Mr. WHITEHOUSE, Mr. KAUFMAN, Mr. FRANKEN, Mr. DODD, Mr. KERRY, and Mr. LEVIN):

S. 1789. A bill to restore fairness to Federal cocaine sentencing; to the Committee on the Judiciary.

Mr. DURBIN. Mr. President, I rise to speak about the Fair Sentencing Act of 2009, which I am introducing today.

This narrowly tailored bill would eliminate the sentencing disparity that exists in the United States between crack cocaine and powder cocaine. At the same time, it would increase penalties for the worst offenders for crimes involving these substances. It accomplishes two very important goals: One goal is to restore fairness to drug sentencing and, second, to focus our limited Federal resources on the most effective way to end violent drug trafficking.

I have cast thousands of votes as a Member of the House of Representatives and the Senate. Most of those votes are kind of lost in the shadows of history. Some were historic, relative to going to war and impeachment issues, and you never forget those.

But there was one vote I cast more than 20 years ago which I regret. It was a vote that was cast by many of us in the House of Representatives, when we were first informed about the appearance of a new narcotic on the streets. It was called crack cocaine. It was so cheap it was going to be plentiful, and it was so insidious—or at least we were told that 20 years ago—we were advised to take notice and do something dramatic and we did.

More than 20 years ago, I joined many Members of Congress from both political parties in voting for the Anti-Drug Abuse Act of 1986. It established the Federal cocaine sentencing framework that is still in place today.

Under this law, it takes 100 times more powder cocaine than crack cocaine to trigger the same 5-to-10-year mandatory minimum sentence. This is known as the 100-to-1 crack/powder sentencing disparity. But that phrase doesn't tell the story. Here is the story. Simply possessing 5 grams of crack, which is the equivalent of holding five packets of sugar or Equal or one of the sugar substitutes, simply possessing that small amount of crack cocaine under the current sentencing framework carries the same sentence as selling—not possessing but selling—500 grams of powder cocaine—the equivalent of 500 packets of sugar. Why? Well, because we believed we were dealing with a different class of narcotics; something that was much more dangerous and should be treated much more harshly.

Make no mistake, cocaine—whether in crack or powder form—has a devastating impact on families and on our society and we need to have tough legislation when it comes to narcotics. But in addition to being tough, our drug laws have to be fair.

Right now, our cocaine laws are based on a distinction between crack and powder cocaine which cannot be justified. Our laws don't focus on the most dangerous offenders. Incarcerating for 5 to 10 years people who are possessing five sugar packets' worth of crack cocaine for the same period of time as those who are selling 500 sugar-size packets of powder cocaine is indefensible.

The Fair Sentencing Act, which I am introducing today, would completely eliminate this crack/powder disparity. It establishes the same sentences for crack and powder—a 1-to-1 sentencing ratio.

Those of us who supported the law establishing this disparity had good intentions. We followed the lead and advice of people in law enforcement. We wanted to address this crack epidemic that was spreading fear and ravaging communities. But we have learned a great deal in the last 20 years. We now know the assumptions that led us to create this disparity were wrong.

Vice President JOE BIDEN, one of the authors of the legislation creating this disparity in sentencing, has said: ''Each of the myths upon which we based the disparity has since been dispelled or altered.''

Earlier this year, I held a hearing in the Senate Judiciary Committee on this disparity in sentencing and we learned the following: Crack is not more addictive than powder cocaine, and crack cocaine offenses do not involve significantly more violence than powder cocaine offenses. Those were the two things that led us to this gross disparity in sentencing between powder cocaine and crack cocaine. We were told it is different; it is more addictive. It is not. We were also told it was going to create conduct which was much more violent than those who were selling powder cocaine and their activities. It did not.

We have also learned that more than 2.3 million people are imprisoned in America today. That is the most prisoners and the highest per capita rate of prisoners of any country in the world, and it is largely due to the incarceration of nonviolent drug offenders in America. African Americans are incarcerated at nearly six times the rate of White Americans. These are issues of fundamental human rights and justice our country must face.

It is important to note that the crack/powder disparity disproportionately affects African Americans. While African Americans constitute less than 30 percent of crack users, they make up 82 percent of those convicted of Federal crack offenses.

At a hearing I held, we heard compelling testimony from Judge Reggie B. Walton, who was Associate Director of the Office of Drug Control Policy under President George H.W. Bush and was appointed by President George W. Bush to the Federal bench. Judge Walton is an African American, and he testified about ''the agony of having to enforce a law that one believes is fundamentally unfair and disproportionately impacts individuals who look like me.''

We also heard about the negative impact the crack/powder disparity has on the criminal justice system. Judge Walton further testified about ''jurors who would tell me that they refused to convict, that even though they thought the evidence was overwhelming, they were not prepared to put another young black man in prison knowing the sentencing disparity that existed between crack and powder cocaine.''

Asa Hutchinson, who was head of the Drug Enforcement Administration under President George W. Bush, testified: ''Under the current disparity, the credibility of our entire drug enforcement system is weakened.''

The crack disparity also diverts resources away from the prosecution of large-scale drug traffickers. In fact, more than 60 percent of defendants convicted of Federal crack crimes are street-level dealers or mules.

During these difficult economic times, it is also important to note that the crack/powder disparity has placed an enormous burden on taxpayers and the prison system. Based on the Bureau of Prison's estimates of the annual costs of incarceration and the U.S. Sentencing Commission's projections of the number of prison beds reduced per year, we know that eliminating this disparity could save more than $510 million in prison beds over 15 years.

There is widespread and growing agreement that the Federal cocaine and sentencing policy in the United States today is unjustified and unjust.

At the hearing I held on the crack/powder disparity, Lanny Breuer, the Assistant Attorney General of the Criminal Division, announced that the Justice Department and this administration support completely eliminating the crack/powder disparity and establishing a 1-to-1 ratio, which is included in my bill.

In June, Attorney General Eric Holder testified before the Senate Judiciary Committee. I asked him about this issue and here is what he said.

> When one looks at the racial implications of the crack-powder disparity, it has bred disrespect for our criminal justice system. It has made the job of those of us in law enforcement more difficult. . . . [I]t is time to do away with that disparity.

Here on Capitol Hill, Democrats and Republicans alike have advocated fixing the disparity for years.

The following 10 Senators are original cosponsors of the Fair Sentencing Act: Senator PATRICK LEAHY, the Chairman of the Judiciary Committee, who for years has advocated for drug sentencing reform; Senator ARLEN SPECTER, the Chair of the Judiciary Committee's Crime and Drugs Subcommittee; Five other members of the Senate Judiciary Committee—Senators RUSS FEINGOLD, BEN CARDIN, SHELDON WHITEHOUSE, TED KAUFMAN, and AL FRANKEN; and Senators JOHN KERRY, CHRIS DODD, and CARL LEVIN.

I would also like to recognize at this point, though he is not a cosponsor of the bill, Senator JEFF SESSIONS, the ranking member of the Judiciary Committee. He has been a leader in calling for reform of crack/powder sentencing policy.

The Senator from Alabama is a former U.S. attorney, not known to be soft on crime in any way, shape, or form, but he was one of the first to speak out about the injustice of the crack/powder disparity. I continue my dialog with Senator SESSIONS in the hope that he and I can come to a common place with regard to this important issue.

There is a bipartisan consensus about the need to fix the crack-powder disparity. I have been in discussions with Chairman LEAHY and Ranking Member SESSIONS, as well as Republican Senators LINDSEY GRAHAM, ORRIN HATCH, and TOM COBURN, and I am confident that the Judiciary Committee can come together to find a bipartisan solution to this problem.

A broad coalition of legal, law enforcement, civil rights, and religious leaders and groups from across the political spectrum supports eliminating the crack-powder disparity, including, for example: Los Angeles Police Chief Bill Bratton, Miami Police Chief John Timoney, The American Bar Association, The Leadership Conference on Civil Rights, The National Black Police Association, and The United Methodist Church.

The bipartisan United States Sentencing Commission has been urging Congress to act for 15 years. They have argued that fixing the crack-powder disparity ''would better reduce the [sentencing] gap [between African Americans and whites] than any other single policy change, and it would dramatically improve the fairness of the federal sentencing system.'' The Sentencing Commission has repeatedly recommended that Congress take two important steps: No. 1, reduce the sentencing disparity by increasing the quantities of crack cocaine that trigger mandatory minimum sentences; and No. 2, eliminate the mandatory minimum penalty for simple possession of crack cocaine. This is the only mandatory minimum sentence for simple possession of a drug by a first time offender.

The bill that I have introduced does both those things.

In order to ensure that limited Federal resources are directed toward the largest drug traffickers and the most violent offenders, not just those guilty of simple possession and a first offense, the Fair and Sentencing Act provides for increased penalties for drug offenses involving vulnerable victims, violence and other aggravating factors.

For example, an individual being prosecuted for possessing either crack or powder cocaine will face more jail time if he: uses or threatens to use violence; uses or possesses a dangerous weapon; is a manager, leader or organizer of drug trafficking activities; or distributes drugs to a pregnant woman or minor.

The bill would also increase the financial penalties for drug trafficking. This sentencing structure will shift Federal resources towards violent traffickers and away from nonviolent drug users who are best dealt with at the State level.

In the final analysis, this legislation is about fixing an unjust law that has taken a great human toll. At the hearing I held in the Judiciary Committee, we heard testimony from Cedric Parker, who is from Alton in my home State of Illinois. In 2000, Mr. Parker's

sister, Eugenia Jennings, was sentenced to 22 years in prison for selling 14 grams of crack cocaine. Mr. Parker told us that Eugenia was physically and sexually abused from a young age. She was addicted to crack by the time she was 15.

Eugenia has three children, Radley, Radeisha, and Cardez. They are now 11, 14, and 15. These children were 2, 5, and 6 when their mother went to prison for selling the equivalent of 6 sugar cubes of crack. They have seen their mother once in the last 9 years. They will be 21, 24, and 25 when she is released in 2019.

At Eugenia's sentencing, Judge Patrick Murphy said this:

Mrs. Jennings, nobody has ever been there for you when you needed it. When you were a child and you were being abused, the Government wasn't there. But when you had a little bit of crack, the government was there. And it is an awful thing, an awful thing to separate a mother from her children. That's what the Government has done for Eugenia Jennings.

It is time to right this wrong. We have talked about the need to address the crack-powder disparity for long enough. Now, it's time to act. I urge my colleagues to join me in supporting the Fair Sentencing Act of 2009.

Mr. SESSIONS. Mr. President, I see my colleague, the assistant majority leader. I know we have been talking about improvement in the sentencing process for crack cocaine. I have offered legislation for almost a decade that would substantially improve the sentencing process in a way that I think is fair and constructive and allows us to deal with serious criminals like drug dealers. I believe it is pretty close to being a good policy. Senator Salazar, now a member of the Obama Cabinet, and Senator MARK PRYOR, my Democratic colleague from Arkansas, Senator JOHN CORNYN from Texas, and I, all four former attorneys general, offered that legislation. Senator DURBIN has some ideas too. I look forward to working with him. I do think it is past time to act.

I will not favor alterations that massively undercut the sentencing we have in place, but I definitely believe that the current system is not fair and that we are not able to defend the sentences that are required to be imposed under the law today.

I am a strong believer in law enforcement and prosecution of those who violate our laws, particularly criminals who really do a lot of damage beyond just dealing drugs. They foster crime and form gangs. People who use cocaine tend to be violent. Even more, in some ways, people who use crack cocaine, as opposed to powder cocaine, tend to be paranoid and violent. It is not a good thing.

We don't need to give up the progress that has been made, but at the same time we need to fix the sentencing. I oppose anything that represents a 50, 60, 70, or 80 percent reduction in penalties but a significant rebalancing of that would be justified.

Mr. LEAHY. Mr. President, today, I am proud to join Senators DURBIN, SPECTER, FEINGOLD, CARDIN, WHITEHOUSE, KAUFMAN, FRANKEN, and others to introduce the Fair Sentencing Act of 2009. Our bill will eliminate the current 100-to-1 disparity between Federal sentences for crack and powder cocaine, equalizing the penalties for both forms of cocaine. I hope that this legislation will finally enable us to address the racial imbalance that has resulted from the cocaine sentencing disparity, as well as to make our drug laws more fair, more rational, and more consistent with our core values of justice.

I commend Senator DURBIN for his leadership in fixing this decades-old injustice. He chaired a hearing before our Crime and Drugs Subcommittee six months ago to examine this issue where we heard from the Assistant Attorney General for the Criminal Division at the Justice Department. We should do what we can to restore public confidence in our criminal justice system. Correcting biases in our criminal sentencing laws is a step in that direction.

Today, the criminal justice system has unfair and biased cocaine penalties that undermine the Constitution's promise of equal treatment for all Americans. For more than 20 years, our Nation has used a Federal cocaine sentencing policy that treats ''crack'' offenders one hundred times more harshly than other cocaine offenders without any legitimate basis for the difference. We know that there is little or no pharmacological distinction between crack and powder cocaine, yet the resulting punishments for these offenses is radically different and the resulting impact on minorities has been particularly unjust.

Under this flawed policy, a first-time offender caught selling five grams of powder cocaine typically receives a 6 month sentence, and would often be eligible for probation. That same first-time offender selling the same amount of crack faces a mandatory five year prison sentence, with little or no possibility of leniency. This policy is wrong and unfair, and it has needlessly swelled our prisons, wasting precious Federal resources.

Even more disturbingly, this policy has had a significantly disparate impact on racial and ethnic minorities. According to the latest statistics assembled by the United States Sentencing Commission, African-American offenders continue to make up the large majority of Federal crack cocaine offenders, accounting for 80 percent of all Federal crack cocaine offenses, compared to white offenders who account for just 10 percent. These statistics are startling. It is no wonder this policy has sparked a nationwide debate about racial bias and undermined citizens' confidence in the justice system.

These penalties, which Congress created in the mid-1980s, have failed to address basic concerns. The primary goal was to punish the major traffickers and drug kingpins who were bringing crack into our neighborhoods. But the law has not been used to go after the most serious offenders. In fact, just the opposite has happened. The Sentencing Commission has consistently reported for many years that more than half of Federal crack cocaine offenders are low-level street dealers and users, not the major traffickers Congress intended to target.

The Fair Sentencing Act of 2009 would return the focus of Federal cocaine sentencing policy to drug kingpins, rather than street level dealers, and address the racial disparity in cocaine sentencing. The legislation we introduce today would align crack and powder cocaine sentences by setting the mandatory minimum sentencing triggers at the same levels. This equalization is a sound way to address the unjust sentencing disparity between crack and powder cocaine.

We have heard calls for this reform from Senators on both sides of the aisle. Senator HATCH, who has called the current ratio ''an unjustifiable disparity,'' recognizes that because ''crack and powder cocaine are pharmacologically the same drug'' our sentencing laws do ''not warrant such an extreme disparity.'' Even Senator SESSIONS, now the ranking Republican member of the Judiciary Committee, has called the 100-to-1 disparity in sentencing between crack cocaine and powder cocaine ''not justifiable'' and called for changes to make the criminal justice system more effective and fair.

The legislation we introduce today would also eliminate the mandatory minimum sentence for possession of crack cocaine. The 5-year mandatory minimum sentence penalty for simple possession of crack is unique under Federal law. There is no other mandatory minimum for mere simple possession of a drug. This bill would correct this inequity, as well. Still, the Federal penalties for drug crimes remain very tough. This bill toughens some of those penalties. It would increase fines for major drug traffickers, as well as provide sentencing enhancements for acts of violence committed during the course of a drug trafficking offense. As a former prosecutor, I support strong punishments for drug traffickers.

This legislation already has support from a broad coalition of groups, including the American Bar Association, the NAACP, the ACLU, Families Against Mandatory Minimums, the Sentencing Project, the United Methodist Church, and many more.

While serving in the Senate, in September 2007, then-Senator Obama said:

If you are convicted of a crime involving drugs, of course you should be punished. But let's not make the punishment for crack cocaine that much more severe than the punishment for powder cocaine when the real difference is where the people are using them or who is using them.

I agree. And the Justice Department agrees as well, as Assistant Attorney

General Lanny Breuer announced at our hearing this spring.

For over 20 years, the ''crack-powder'' disparity in the law has contributed to swelling prison populations without focusing on the drug kingpins. We must be smarter in our Federal drug policy. Law enforcement has been and continues to be a central part of our efforts against illegal drugs, but we must also find meaningful, community-based solutions.

American justice is about fairness for each individual. To have faith in our system Americans must have confidence that the laws of this country, including our drug laws, are fair and administered fairly. I believe the Fair Sentencing Act of 2009 will move us one step closer to reaching that goal. I urge all Senators to support this measure.

Mr. SPECTER. Mr. President. I have sought recognition to urge support for the legislation introduced today by Senator DURBIN to completely eliminate the unfair and unwarranted sentencing disparity between crack and powder cocaine. I am an original cosponsor of this bill.

Since the passage of the Anti-Drug Abuse Act of 1986, which established the basic framework of mandatory minimum penalties currently applicable to Federal drug trafficking offenses, there exists a 100-to-1 ratio between crack and powder cocaine. That means it takes 100 times as much powder cocaine as crack to trigger the same 5-year and 10-year mandatory minimum penalties.

On April 29, 2009, 6 witnesses testified before the Senate Judiciary Subcommittee on Crime and Drugs regarding the sentencing disparity between crack and powder cocaine, including the Assistant Attorney General for the Criminal Division at the Department of Justice, the Acting Chair of the U.S. Sentencing Commission, a U.S. District Court Judge representing the Judicial Conference of the U.S. Courts, and a Police Commissioner from a major urban city. All six witnesses testified in favor of an immediate reduction or elimination of this disparity.

At the time Congress established the crack-powder disparity in 1986, it did so because it was believed that crack was uniquely addictive and was associated with greater levels of violence than powder cocaine.

Today, more than 20 years later, research has shown that the addictive qualities of crack have more to do with its mode of administration—smoking compared to inhaling—rather than its chemical structure. Moreover, recent studies suggest that levels of violence associated with crack are stable or even declining.

Last year, 80.6 percent of crack offenders were African Americans, while only 10.2 percent were white. Compare that with powder cocaine prosecutions. For that same year, 30.25 percent of powder cocaine offenders were African Americans, 52.5 percent were Hispanic, and 16.4 percent were white. The average sentence for crack offenders is 2 years longer than the average sentence for powder cocaine.

Let me repeat that. African Americans, who make up approximately 12.3 percent of the population in the U.S., comprise 80.6 percent of the Federal crack offenders.

It takes about $14,000 worth of powder cocaine compared to only about $150 of crack to trigger the 5-year mandatory minimum penalty. Given that crack and cocaine powder are the same drug—just in different forms—why should we impose the same 5-year sentence for the $150 drug deal as for the $14,000 drug deal?

These sentencing disparities undermine the confidence in the criminal justice system. Our courts and our laws must be fundamentally fair; just as importantly, they must be perceived as fair by the public. I do not believe that the 1986 Act was intended to have a disparate impact on minorities but the reality is that it does.

The White House and the Department of Justice have asked Congress to eliminate this unfair sentencing disparity. It is time to correct this injustice.

By Mr. DORGAN (for himself, Mr. REID, Ms. MURKOWSKI, Mr. UDALL of New Mexico, Mr. WHITEHOUSE, Mr. JOHNSON, Mr. TESTER, Mr. AKAKA, Mr. CONRAD, Mr. BEGICH, Mr. FRANKEN, Mr. BURRIS, Mr. INOUYE, Ms. STABENOW, Mr. UDALL of Colorado, and Ms. KLOBUCHAR):

S. 1790. A bill to amend the Indian Health Care Improvement Act to revise and extend that Act, and for other purposes; to the Committee on Indian Affairs.

Mr. DORGAN. Mr. President, today I introduced the Indian Health Care Improvement Reauthorization and Extension Act of 2009. We face a bona fide crisis in health care in our Native American communities, and this bill is a first step toward fulfilling our treaty obligations and trust responsibility to provide quality health care in Indian Country. I introduce this bill on behalf of myself, Leader REID and Senators MURKOWSKI, UDALL of New Mexico, BEGICH, FRANKEN, WHITEHOUSE, INOUYE, AKAKA, JOHNSON, TESTER, CONRAD, BURRIS, STABENOW, UDALL of Colorado, and KLOBUCHAR.

As Chairman of the Senate Committee on Indian Affairs, I have again made health care a top priority for the Committee this Congress. Native Americans suffer staggering health disparities due to an outdated, strained and underfunded health care system. We have a federal health care system for Native Americans that is only funded at about half of its need. Clinician vacancy rates within this system are high and misdiagnosis is rampant. Only those with ''life or limb'' emergencies seem to get care. Native Americans die of tuberculosis at a rate 600 percent higher than the general population, suicide rates are nearly double, alcoholism rates are 510 percent higher, and diabetes rates are 189 percent higher than the general population.

These numbers are appalling and represent Third World conditions right here in the U.S.

I have heard the heartbreaking stories about the lack of health care on our Native American reservations: people like Ta'shon Rain Littlelight, Jami Rose Jetty, Russell Lente and Avis Little Wind, who likely still would be living today had they had access to adequate health care. Our Federal system has failed them and so many other Native Americans. We owe our First Americans something better, and the bill I introduced today with my colleagues will provide a better system.

For over a decade, Indian Country has asked Congress to reauthorize and amend the Indian Health Care Improvement Act, P.L. 94–437. The National Steering Committee for Reauthorization, National Congress of American Indians, National Indian Health Board, and other Native American health advocates have been dedicated to improving the health care available to Native Americans across the country. I too am committed to ensuring the United States fulfills its trust responsibility to provide decent health care to the Native Americans.

Last Congress, the Senate passed the Indian Health Care Improvement Act Amendments of 2008, which would have brought needed improvements to the Native American health care system. The bill passed by an overwhelming 83 to 10 vote. This was the first time in almost 17 years that the Senate considered and passed a Native American health care bill. Ultimately, the bill failed to be considered in the House of Representatives. My colleagues and I remain committed to getting a bill enacted into law.

In July, I developed a Native American health concept paper which was sent out to Indian Country for comments. I and the Committee on Indian Affairs held many listening sessions and meetings with many Native Americans around the country to discuss the concept paper. In addition, the Committee has held five hearings focused on Native American health issues this Congress. The Committee has worked to compile the feedback received from the concept paper and other meetings to develop the Native American health bill I introduced today.

Similar legislation has been considered in the 106, 107, 108, 109, and 110 Congresses. Today, my colleagues and I put forward a Native American health bill for the 111 Congress which builds on the work of prior Congresses, but goes beyond to include innovative solutions and reforms for the Native American health care system.

I would like to highlight some of the important updates the Indian Health Care Improvement Reauthorization and Extension Act of 2009 will bring to

the Native American health care system.

Perhaps most importantly, the Native American health bill permanently reauthorizes all current laws governing the Native American health care system. This means that once this bill is passed, Indian Country will never again have to wait nearly 20 years for a reauthorization of the Indian Health Care Improvement Act.

This bill also authorizes long-term care services, including hospice care, assisted living, long-term care and home- and community-based care. Current law does not allow for these services to be provided by the Indian Health Service or tribal facilities. Although some areas of Indian Country are merely focused on addressing life or limb medical emergencies, other areas are in need of long-term care. Thus, I believe they should be authorized.

In addition, the bill establishes mental and behavioral health programs beyond alcohol and substance abuse, such as fetal alcohol spectrum disorders, child sexual abuse and prevention treatment programs. The mental health needs in Native American communities extend beyond alcohol and substance abuse, in fact over ⅓ of the health care needs in Indian Country are related to mental health. The comprehensive mental and behavioral health programs established as a result of this bill will bring necessary care and resources to Native Americans.

In order to address the tragic level of youth suicide, the bill includes behavioral health provisions solely focused on preventing Native American youth suicide. The youth suicide rate in Indian Country is 3.5 times higher than the general population. Earlier this year, I chaired an Indian Affairs hearing to draw attention to this important topic.

The bill also incorporates many new ideas aimed at improving the access to health care available to Native Americans. The bill authorizes projects which will incentivize tribes to use innovative facilities construction which save money and expand the health care services available to Native American communities. For example, these projects include the use of modular component facility construction and mobile health stations.

Modular component health facilities can be built at often one-third the cost and a fraction of the time of a typical health facility. In addition, mobile health stations will allow for Native Americans in rural areas without a hospital, increased access to specialty health services like dialysis, same-day surgery, dental care, or other services. Currently, there is an estimated $3 billion backlog for maintenance, improvement and construction of Native American health care facilities. In addition, the average age of an Indian Health Service facility is 33 years, as compared to 7 years in the general population. These innovative health care facilities will go a long way in this disparity and improving access to health care for Native Americans across the country.

The Native American health bill establishes a health delivery demonstration project. This project provides for convenient care services, which could be offered in local grocery stores and other venues, to make health care more available to Native American communities. The health delivery demonstration project authorizes the Indian Health Service to consider other innovative health delivery models, like community health centers, and other models which will increase access to health care services.

I want to end by saying the need for health care is not new for Indian Country. Nowadays, the need for national health care reform is front page news, but our Native Americans have long been in need of health care reforms. Therefore, I intend to offer this Native American health bill as an amendment to any national health care reform bill considered on the Senate floor.

I want to thank all the Native American health advocates who assisted us in the development of this crucial piece of legislation. The Federal Government signed the dotted lines years ago, and today, we make an important step towards finally fulfilling those obligations.

AMENDMENTS SUBMITTED AND PROPOSED

SA 2691. Ms. SNOWE (for herself, Mr. KERRY, and Mr. KIRK) submitted an amendment intended to be proposed by her to the bill H.R. 2847, making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 2691. Ms. SNOWE (for herself, Mr. KERRY, and Mr. KIRK) submitted an amendment intended to be proposed by her to the bill H.R. 2847, making appropriations for the Departments of Commerce and Justice, and Science, and Related Agencies for the fiscal year ending September 30, 2010, and for other purposes; which was ordered to lie on the table; as follows:

On page 124, line 21, strike ''section.'' and insert ''section, including an assessment of actions other than increased Federal spending that would improve the development and interdepartmental coordination of the policies of the United States under the United States–Canada Transboundary Resource Sharing Understanding for shared groundfish stocks.''.

NOTICES OF HEARINGS

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on National Parks.

The hearing will be held on Wednesday, October 28, 2009, at 2:30 p.m. in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the current and expected impacts of climate change on units of the National Park System.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to the Committee on Energy and Natural Resources, United States Senate, Washington, DC 20510–6150, or by email to allison_seyferth@energy.senate.gov.

For further information, please contact Sara Tucker at (202) 224–6224 or Allison Seyferth at (202) 224–4905.

COMMITTEE ON ENERGY AND NATURAL RESOURCES

Mr. BINGAMAN. Mr. President, I would like to announce for the information of the Senate and the public that a hearing has been scheduled before the Subcommittee on Public Lands and Forests.

The hearing will be held on Thursday, October 29, 2009, at 2:30 p.m., in room SD–366 of the Dirksen Senate Office Building.

The purpose of the hearing is to receive testimony on the following bills:

S. 555, to provide for the exchange of certain land located in the Arapaho-Roosevelt National Forests in the State of Colorado, and for other purposes;

S. 607, to amend the National Forest Ski Area Permit Act of 1986 to clarify the authority of the Secretary of Agriculture regarding additional recreational uses of National Forest System land that are subject to ski area permits, and for other purposes;

S. 721, to expand the Alpine Lakes Wilderness in the State of Washington, to designate the Middle Fork Snoqualmie River and Pratt River as wild and scenic rivers, and for other purposes;

S. 1122, to authorize the Secretary of Agriculture and the Secretary of the Interior to enter into cooperative agreements with State foresters authorizing State foresters to provide certain forest, rangeland, and watershed restoration and protection services;

S. 1328 and H.R. 689, to interchange the administrative jurisdiction of certain Federal lands between the Forest Service and the Bureau of Land Management, and for other purposes;

S. 1442, to amend the Public Lands Corps Act of 1993 to expand the authorization of the Secretaries of Agriculture, Commerce, and the Interior to provide service-learning opportunities on public lands, establish a grant program for Indian Youth Service Corps, help restore the Nation's natural, cultural, historic, archaeological, recreational, and scenic resources, train a new generation of public land managers and enthusiasts, and promote the value of public service; and

H.R. 129, to authorize the conveyance of certain National Forest System lands in the Los Padres National Forest in California.

Because of the limited time available for the hearing, witnesses may testify by invitation only. However, those wishing to submit written testimony for the hearing record should send it to